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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIFTH APPELLATE DISTRICT

THE PEOPLE, Plaintiff and Respondent, v. JOHNNYE RAY VARGAS, Defendant and Appellant.	F077201 (Super. Ct. No. 35230) **OPINION**

THE COURT[*]

APPEAL from an order of the Superior Court of Stanislaus County. Nancy Ashley, Judge.

Conness A. Thompson, under appointment by the Court of Appeal, for Defendant and Appellant.

Xavier Becerra, Attorney General, Gerald A. Engler, Chief Assistant Attorney General, Michael P. Farrell, Assistant Attorney General, Carlos A. Martinez and Marcia A. Fay, Deputy Attorneys General, for Plaintiff and Respondent.

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[*] Before Poochigian, Acting P.J., Franson, J. and Snauffer, J.

Vargas appeals from an order denying him release on outpatient status following a hearing pursuant to Penal code section 1604.[1] On appeal, Vargas contends the court abused its discretion when it denied him release on outpatient status because the evidence did not support the court's finding that he presented a substantial risk of physical harm to others. We affirm.

FACTS

Background

On November 12, 1982, when Vargas was 21 years old, during a walk with his former girlfriend, he became angry, hit her hard, and tripped her. He then kicked her to death.

On November 21, 1983, Vargas was committed to Atascadero State Hospital after being found incompetent to stand trial pursuant to section 1370. He was subsequently committed two more times.

By September 15, 1987, Vargas's competency had been restored and on that date the district attorney filed an information charging him with murder (§ 187).

On December 9, 1987, Vargas pled guilty to second degree murder and the parties stipulated that he could submit a plea of not guilty by reason of insanity. The plea and stipulation were based on Dr. Steven Carmichael's report in which he diagnosed Vargas, in pertinent part, as suffering primarily from avoidant personality disorder and schizophrenia, paranoid type.

On January 7, 1988, Vargas was committed to Atascadero State Hospital for a maximum term of life.

On March 5, 1993, he was transferred to Napa State Hospital (NSH).

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1 All further statutory references are to the Penal Code.

On November 21, 2017, on its own motion, the court set the matter for further proceedings based on the recommendation of NSH that Vargas be released to the conditional outpatient treatment program (CONREP) for outpatient treatment.

The Hearing

On February 27, 2018, at a hearing on the recommendation, the defense presented four expert witnesses. Dr. Katarzyna Krawczyk, a staff psychiatrist at NSH, testified that Vargas had been a patient of hers at the hospital for the last four years and that she saw him at least monthly on the discharge unit, the least restrictive unit at NSH. Vargas took two antipsychotic medications on his own, without prompting by staff, that controlled his symptoms. Vargas was aware he suffered from a mental illness and that he needed to treat his illness for the rest of his life. Vargas completed a detailed relapse program for both his mental illness and substance abuse issues. Vargas was able to recognize his triggers and when he began having symptoms he was able to report them to staff. In Krawczyk's opinion, Vargas was suitable for conditional release.

On cross-examination, Krawczyk testified she was familiar with the facts surrounding Vargas's offense and that in 2014 Vargas experienced hallucinations that told him to cut himself. Krawczyk acknowledged that the unit Vargas was in at NHP was more restrictive than CONREP and she could not testify to the level of supervision he would receive in that program. Krawczyk also acknowledged Vargas would pose a higher risk of danger to others if he did not take his medications but she opined Vargas would take them if discharged to CONREP because he had developed good insight into his mental illness and he knew his triggers and symptoms.

Dr. Richard Kepner, a clinical psychologist at NHP, testified that he wrote an HCR-20 report, dated July 29, 2016, for Vargas based on records, observation, and interviews with Vargas. The report assessed Vargas's risk of violence for the ensuing 12 months by assessing 10 historical factors, five clinical factors, and five risk

management factors. Kepner found Vargas had the following historical risk factors which he described as: "history, violence, relationships, employment, substance abuse, and [a] major mental disorder." He did not find any clinical risk factors, i.e., factors involving his present clinical condition, but he found one potential risk management factor, i.e., stress or coping. In Kepner's opinion, Vargas's risk of violence for the next 12 months was low if he were released in the community with supervision. Based on his report and a review of the records he used to prepare it, Kepner opined Vargas was suitable for conditional outpatient treatment under CONREP.

During cross-examination, Kepner acknowledged Vargas posed a greater risk for violence if he used substances, stopped participating in treatment for his mental illness, or experienced a high amount of stress without supervision or support. He also acknowledged Vargas received a greater amount of supervision at NSH than he would receive at CONREP, but it was his understanding patients discharged to CONREP received very close supervision when they first left the hospital. Kepner also conceded that Vargas might experience problems in the community with stress and coping because of his schizophrenia and from being in a new environment. Although Kepner believed stress alone would not lead to more violence by Vargas, stress combined with a lack of medication for his schizophrenia could cause Vargas to pose a substantial danger of physical harm to others. However, Kepner was sure Vargas would take his medication because he would be closely supervised at CONREP. When asked if Vargas would be able to leave the CONREP facility, Kepner was not sure and he admitted not being completely familiar with the program and knowing exactly "how it works."

Paul Cervelli, a social worker for Central Valley CONREP, reviewed records including Vargas's psychiatric progress reviews and psychologist reports, and he spoke to nurses and other staff regarding Vargas. According to Cervelli, Vargas had been compliant with his clinical and medical treatment. Further, NSH had concluded that

Vargas's risk for violence at the hospital within the next 12 months was low and that it was also low in the community if he were supervised. Cervelli further testified that Vargas had good insight into his mental illness and knew his triggers, warning signs and precursors. In April 2017, Vargas shared with Cervelli that in the event he experienced any warning signs, triggers, or symptoms, he would cope with them by talking about them. This was important for being released into the community because the inability to identify symptoms could lead to problems and CONREP might not accept someone who did not have any coping strategies. Cervelli also testified that Vargas participated in group sessions and he continued to make adjustments to his forensic relapse prevention plan.

Upon being released from NHP, Vargas would probably spend 90 to 120 days at a statewide residential program (STRP), a facility that is highly supervised and has the authority to re-hospitalize a patient. When Vargas completed STRP, he would be released to the Central Valley CONREP and placed in level 1[2] where he would be housed in a structured setting with other residents who would mentor him and help him take transportation to the office. Staff on site would help him take medication, which would be provided. Although less structured than NHP, Vargas would receive treatment at CONREP four to five days a week and staff would be at his residence several of those days.

At CONREP, Vargas would be placed in core groups and day socialization groups. He would also be able to participate in group and individual sessions and this would help his primary therapist develop a treatment program for him. Every Tuesday CONREP staff discuss issues and concerns regarding patients for five hours. Additionally, Vargas

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2 There are five levels at CONREP, from intensive to aftercare, with each level being less restrictive, and there is no timeline for treatment. Cervelli's testimony focused on level 1.

would be required to initial and sign his terms and conditions of outpatient treatment. If he violated any of them or refused or missed his medication, CONREP could re-hospitalize him. Cervelli opined that Vargas should be released on a conditional release program.

On cross-examination, Cervelli testified that STRP was not as controlled as NSH, it was not a locked facility, except at night, and during the day there was nothing to prevent a patient from leaving the facility without authorization. CONREP also was not a locked facility and there also would be nothing to prevent Vargas from leaving that placement without authorization. Cervelli acknowledged that alcohol was one of Vargas's triggers and if released on outpatient status, Vargas would "possibly" be around alcohol more than if he were at NSH because in the community there are commercials, liquor stores, "and things like that." Additionally, Vargas reported to Cervelli that just smelling alcohol could be a trigger for him and if alcohol were in front of him or he saw people around him drinking, he would get angry. Cervelli, however, insisted that they tried to prepare Vargas for the increased exposure to alcohol he would experience on outpatient status and if he could not handle it, he would be re-hospitalized.

Rhonda Love, the community program director at Central Valley CONREP, testified Vargas met all the requirements established for community outpatient readiness. She also testified regarding the structure of STRP and CONREP and the services they would provide Vargas. Love opined that Vargas was suitable for placement in the community.

During cross-examination, Love acknowledged that neither STRP nor CONREP are locked-down facilities and at STRP, Vargas would be able to come and go as he pleased. However, he would have curfews and be expected to follow the terms and conditions that would be structured for him and approved by the court, as well as the

rules established in his living environments. She acknowledged, however, that there was no guarantee he would be compliant with these requirements.

In denying the recommendation of outpatient status for Vargas and ordering his continued commitment to NHS, the court stated:

> "I just have a tremendous trepidation, after 30 years of treatment, for this individual that all of the sudden he's eligible–or suitable for outpatient treatment, especially given the comments that he himself made regarding alcohol, regarding his triggers as well.
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> "I'm not satisfied with what I heard from what the witnesses testified to as the type of structure that Mr. Vargas would be in. I have tremendous concern that he does pose a threat to society, and also obviously if he were not to comply that likely is too late by the time he's returned to the hospital. It would have to be for some sort of reason.
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> "I'm not satisfied, based on what I heard, and what the type of structure he'd be in that he is no longer a danger to the community.
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> "So my finding is that he's not eligible for outpatient–community outpatient treatment, and should continue in [NHP], or the Department of State Hospitals for continued treatment."

DISCUSSION

Vargas contends the court's reasons for denying him conditional release to outpatient status were arbitrary because they were not supported by the record or were inadequate. Thus, according to Vargas, the court abused its discretion when it ordered that he remain at NSH because the court's order is not supported by substantial evidence. We disagree.

"When the trial court finds that defendant was insane at the time of the offense, it may commit defendant to a state hospital or certain public or private treatment facilities, or it may order defendant placed on outpatient status pursuant to section 1600 et seq. (§ 1026, subd. (a).) …

"Upon such a commitment, the medical director of the facility submits semi-annual reports to the court. (§ 1026, subd. (f).) … [□] A person may be released from a state hospital (1) upon restoration of sanity pursuant to the provisions of section 1026.2, (2) upon expiration of the maximum term of commitment under section 1026.5 [citation], or (3) upon approval of outpatient status pursuant to the provisions of section 1600 et seq. (§ 1026.1.)

"Under the latter procedure [which is at issue here], a defendant may be placed on outpatient status if the director of the state hospital and the community program director so recommend, and the trial court approves the recommendation after hearing. (§ 1603.) [□] 'Outpatient status is not a privilege given the [offender] to finish out his sentence in a less restricted setting; rather it is a discretionary form of treatment to be ordered by the committing court only if the medical experts who plan and provide treatment conclude that such treatment would benefit the [offender] and cause no undue hazard to the community.' " (*People v. Sword* (1994) 29 Cal.App.4th 614, 619–620 (*Sword*).)

"The release decision is not solely a medical or expert decision. The court's role is to apply a community standard to the release decision: 'In a democratic society, we believe, the function of delimiting dangerousness *for release purposes* belongs to the community. Translating community values and policies into an operational definition of dangerousness has been assigned initially to legislators and then to judges as construers of legislative determinations, and not to any particular administrative or professional group, including psychiatrists.' [Citation.] Accordingly, the judge's role is not to rubber-stamp the recommendations of the [hospital] doctors and the community release program staff experts. Those recommendations are only prerequisites for obtaining a hearing. (§ 1602.) The fact that the statute requires the trial court to approve or disapprove the expert's recommendations shows the discretion placed in the trial court. (§ 1604, subd. (d).)" (*Sword, supra,* 29 Cal.App.4th at p. 628.)

The "defendant has the burden of proving, by a preponderance of the evidence, that he is either no longer mentally ill or not dangerous." (*Sword, supra*, 29 Cal.App.4th at p. 624.)

"[T]he proper standard of review is abuse of discretion. (*People v. Sword*, *supra*, 29 Cal.App. 4th at pp. 619, fn. 2, 626.) Under that standard, it is not sufficient to show facts affording an opportunity for a difference of opinion. [Citation.] 'A trial court's exercise of discretion will not be disturbed unless it appears that the resulting injury is sufficiently grave to manifest a miscarriage of justice. [Citation.] In other words, discretion is abused only if the court exceeds the bounds of reason, all of the circumstances being considered. [Citation.]' [Citation.]

"Under section 1026.2, the trial court must determine whether the applicant 'would be a danger to the health and safety of others, due to mental defect, disease, or disorder, if under supervision and treatment in the community.' (§ 1026.2, subd. (e).) If the court determines the applicant will not, the court 'shall' order the applicant to be placed with an appropriate forensic conditional release program for one year. (*Ibid*.) Under section 1604, subdivision (c), the court also 'shall consider the circumstances and nature of the criminal offense leading to commitment and shall consider the person's prior criminal history.' Under section 1602, subdivision (a)(3), the court must specifically approve the recommendation and plan for outpatient status." (*People v. Cross* (2005) 127 Cal.App.4th 63, 73.) "The trial court [is] not required to follow the … recommendations of the expert witnesses [even if unanimous]. [Citation.] However, it [can] disregard those recommendations only for nonarbitrary reasons." (*Ibid*.)

The trial court's comments denying the recommendation of outpatient status for Vargas indicate the court was primarily concerned that alcohol was such a potent trigger for Vargas and that the degree of supervision at STRP and CONREP would allow him to

leave either placement without authorization, which would result in his probable exposure to that trigger. Its concerns are adequately supported by the record.

Vargas committed a horrendous murder while in a schizophrenic state. At the time of the hearing, Vargas continued to suffer from schizophrenia and he required two medications to control its symptoms. Kepner acknowledged that if released on outpatient status, Vargas might experience problems with stress and coping by virtue of being in a new environment. He also acknowledged that Vargas's failure to take his medications combined with stress could cause Vargas to pose a substantial danger of physical harm to others. Kepner was confident Vargas would take his medications at CONREP because it provided close supervision and there was evidence that he was compliant with his medications and programs at NSH, which was a locked facility. However, at CONREP Vargas would only be closely supervised four or five days a week when he participated in its programs and when a representative was at his residence during some of those days. Further, CONREP was not a locked-down facility and STRP was not locked during the day. Thus, Vargas would have ample opportunity to evade the close supervision of either placement by absconding.

Moreover, Vargas admitted the smell of alcohol alone was a trigger and that the sight of alcohol or people drinking would cause him to get angry. Given the prevalence of alcohol in society, including its seemingly universal availability, if he left either placement without authorization, even for a short period of time, he would likely be exposed to this trigger. At CONREP, the probability that he would be exposed to alcohol would be much greater because he would only be under close supervision four to five days a week. Additionally, if he absconded he would lose access to his medication which, along with his exposure to alcohol, would further increase his potential danger to others.

Further, although Vargas's witnesses testified that he had developed good insight into his mental illness, knew his triggers and symptoms, had coping strategies, and had completed a detailed relapse prevention program, none testified with any specificity how this would assist him in dealing with this powerful trigger in light of the prevalence of alcohol in the community. Thus, the court's reasons for denying the order for outpatient treatment were not arbitrary because they are supported by the evidence.

Vargas contends the record does not support the court's concern that alcohol was a trigger for him because: (1) alcohol was not involved in his underlying murder offense and there was no evidence that exposure to advertisements or liquor stores would cause him to get drunk and turn violent; and (2) he presented evidence that he had developed good insight into his mental illness, knew his triggers, knew his symptoms, and had completed a detailed relapse prevention program for his mental illness and substance abuse. Regardless of whether alcohol was involved in Vargas's commitment offense, as noted above, alcohol was a powerful trigger for Vargas and none of the experts explained with any specificity how the skills he learned would help him cope with the exposure to alcohol he was bound to encounter in an outpatient placement.

Vargas also downplays the court's reliance on the structure of STRP and CONREP by emphasizing the restrictiveness of these placements and his compliance with the program at NSH. However, as also noted above, at CONREP Vargas would only be closely supervised four to five days a week and at both placements he would have ample opportunity to abscond.

Vargas further contends that the court's concern about his potential failure to comply with medication is not supported by the record and ignores section 1608, which would allow Vargas's outpatient status to be revoked and the court to confine him pending a hearing on the matter. (§§ 1608, 1609, 1610, subd. (a).) But, those procedures would be effective only if implemented before Vargas became violent and there was no

way for the court to ensure that they would be. Thus, we conclude that the court did not abuse its discretion when it found that Vargas was not suitable for outpatient treatment and ordered him recommitted to NSH.

DISPOSITION

The court's order is affirmed.